Sameh Kassem D.D.S

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AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's Name: Date of Birth:

I, hereby authorize the release of my dental records.

I ,_____(Parent/ Guardian) hereby authorize the release of dental records for the patient named above to:

[Name]
[Street address]
[City, ST ZIP Code]

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ◉ Other

- Please send Records to the following location:

- I will pick up my dental records at the office

- _____ is authorized to pick up my dental records

Patient
Signature:_____